STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: SOUTH DAKOTA

Requirements for Third Party Liability -
Payment of Claims

Health insurance information, in general, will be obtained and noted in the third party data file and the eligibility file at the time of application, and whenever there is a renewal of eligibility . In addition this information will be inserted in these files within ten days of the agency being made aware that there is health insurance available from a source other than the application process.

I. Data exchanges are conducted monthly with the State Wage Collection Agency-South Dakota Employment Security (Department of Labor), Social Security Administration (SSA), and Internal Revenue Service (IRS).

II. The South Dakota IEVS is completely on-line and is paperless. The IEVS verfication system in South Dakota is tied into the interface modules of the FAMIS certified eligibility system ACCESS. Basically all matches follow the same procedure. South Dakota creates a tape that contains all recipients that are considered to be in an active or pending status. The tape is sent to the agency the match is to be performed with, they in turn send the tape back to the State Agency and the tape is matched to ACCESS and the interface panels are built. As the interfaces are stored, the data on the verification record received is targeted, and the discrepancies stored on ACCESS verification panels. The workers are notified that a verification run has been made, and they should check their worker-to-do report for disrepancies that must be resolved.

Each worker will have an on-line report that will indicate the verifications that he/she must resolve. The number of days allowed for completion of data exchange information is 45 days. The report will indicate the number of days left out of the 45 allotted days, or how many days overdue the verification is.

If the verification results in an overpayment, the worker begins the process of establishing a claim. In this instance mail is sent to the workers supervisor and the supervisor will approve the claim. At this time a skeleton claim is established on the Office of Recoveries and Investigations System. Mail is sent to the recovery investigator indicating the claim was established and forms will be coming.

The worker must enter a short narrative on the verification as they are completing it. A history is kept of all actions that were taken before a verification is completed.

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III. Data exchange with State Motor Vehicle accident records are matched with Medicaid records every month. The Office of Recoveries and Investigations matches the two agencies through a printout and researches the possibility of TPL payment. Verification is made directly with the client, insurance companies, and field workers concerning the pursuit of TPL.

IV. Worker's Compensation claim information files, other than for state employees, have not been computerized at this time. This matching process is currently in the computer development stage. The proposed system will match on first claim information. The matching process will automatically expand as additional workers are added to the computer file.

V. Diagnosis and Trauma codes are edited prior to payment of claims according to the codes indicated in the State Medical Assistance Manual. The claims are pended for review and then paid. On a weekly basis a letter to every recipient for whom claims, with these selected codes, have been paid during that week is generated by the computer. Also there is a weekly computer report generated as a backup to the letter system to assure that all letters are received. The letters are reviewed and mailed by a staff member of the Office of Recoveries and Investigations that has been assigned to work with Accident/Trauma claims.

If a positive response is received from the letter indicating third party liability has been established or litigation is to be initiated, a computer printout of paid claims will be requested. The Office of Recoveries and Investigation secures all necessary information and submits claims to the third party when liability has been established. Whenever the response indicates that litigation has been or will be initiated, all claim information will be gathered and the attorney involved in the litigation will be contacted regarding the State's right to third party recovery of medical expenditures made on behalf of the recipient.

An annual review will be done of a computer log that has recorded diagnosis and trauma codes from claims during the past year to determine those codes that are the most productive for third party recovery action. This log is maintained throughout the year with information on letters mailed to clients, responses received, and the result of recovery action. Waiver requests will be submitted for those codes that have little or no response so that the codes may be deleted from the trauma edits.